GENETIC CARE CENTRE

Name……..... **Referred by**…….....

Date of birth..... **Age** ……**Male/Female**.....

Contact Tel Numbers……..... **Email**…….....……..

Please complete this form in the event of a previous COVID-19 diagnosis and /or vaccination

Metabolic Syndrome Score	How many, if any, of the following 4 risk factors did you have **before** the time of infection (0-4): Overweight/obese, Dyslipidaemia/high cholesterol, Hypertension, Type II diabetes: YOUR SCORE =
Date of Acute COVID-19 positive diagnosis (and copy of laboratory report if possible):	
Duration of Acute COVID-19 (and any resulting health problems after positive COVID-19 test):	
COVID-19 medication (provide other treatment on next page):	

Long COVID diagnosis (if applicable)			
Were you diagnosed with Long COVID?		Yes	No
If YES, please complete the following:			
Date of Long COVID diagnosis			
Severity of Long COVID	**Light**	**Medium**	**Severe**
Status of COVID-19 infection	**First infection**	**Reinfection**	**Vaccine breakthrough**
Were you hospitalized?		Yes	No
Did you receive oxygen?		Yes	No
Were you ventilated?		Yes	No
Please specify specific Long COVID symptoms (before vaccination, if applicable)			

Vaccine Side Effects (if applicable)			
If vaccinated, please give name of vaccine	Pfizer	Johnson & Johnson	Other:
Date(s) of vaccination			
Did you experience any of the following after vaccination?			
Pain, swelling or redness at injection site		Yes	No
Muscle twitching		Yes	No
Pain (e.g. peripheral neuropathy)		Yes	No
Inflammation of the heart		Yes	No
Fever		Yes	No
Chills		Yes	No
Tiredness		Yes	No
Other flu-like symptoms		Yes	No
If YES, please specify together with any other symptoms after vaccination:			

PLEASE ALSO PROVIDE RELEVANT/AVAILABLE PATHOLOGY RESULTS (COVID-19 test, Lipid profile/cholesterol, homocysteine,glucose, ferritin levels, and histology/immunohistochemistry in the case of cancer patients), OR

APPROVAL TO REQUEST INFORMATION FROM YOUR DOCTOR / LABORATORY ☐ YES ☐ NO

Please provide personal and family medical history <u>BEFORE COVID-19</u> diagnosis/vaccination					
Reason for genetic testing: (e.g. disease with familial risk, lifestyle-triggered genetic risk, therapy-associated risk)					
Previous genetic tests performed: (Please provide previous laboratory reports if possible, e.g. *BRCA1/2)*					
Medical Condition (before COVID-19 infection and/or vaccination)	**Patient** (Y/N)	**Age of Onset**	**Current medication of patient**	**Family Relationship** (e.g. mother, brother)	**Age of Onset**
Cancers (please provide histopathology, IHC, FISH reports)					
Breast cancer					
Colorectal cancer					
Ovarian cancer					
Prostate cancer					
Other (specify) ……..					
Hereditary biochemical diseases					
Hemochromatosis					
Hypercholesterolemia					
Metabolic and brain disorders					
Alzheimer's disease					
Anaemia / iron deficiency					
Angina / Coronary heart disease					
Arthritis / Osteoarthritis					
Chronic periodontitis					
Deep vein thrombosis					
Diabetes type I					
Diabetes Type II					
High blood cholesterol					
High blood iron					
High blood pressure					
Multiple Sclerosis					
Non-alcoholic fatty liver disease					
Osteoporosis					
Peripheral vascular disease					
Porphyria (specify type)					
Pulmonary embolism					
Recurrent pregnancy loss					
Restless legs syndrome					
Stress, Anxiety, Depression					
Stroke					
Other conditions or symptoms (e.g. skin problems, allergies, insomnia)					

Please provide the following information for the Wellness Screen NCD Pathways Report

Chronic medication taken previously?			Y	N	Name medication				
Chronic medication taken currently?			Y	N	Name medication				
Change of medication / dosage considered?			Y	N	Name medication				
Treatment failure / side effects?			Y	N	Name medication				
MEDICATION SIDE EFFECTS (Please Specify)									
Anti-depressants (e.g. weight gain)			Y	N	Aromatase inhibitors (e.g. muscular skeletal inflammation, bone density reduction/loss)			Y	N
Cholesterol-lowering statins (e.g. muscle pains)			Y	N	Tamoxifen (e.g. deep vein thrombosis)			Y	N
Other medication side effects (e.g. weight gain/dyslipidaemia with ARVs or depression with immunomodulating drugs):									
Did you Previously [P] or Currently [Y] take:					**Blood Pressure Medication:**			Y	N	P
Oral Contraceptive Pill?	Name + duration		N	P	Systolic Blood Pressure	mmHg	Diastolic Blood Pressure			mmHg
Hormone Replacement Therapy?	Name + duration		N	P	Iron injections?	Y	N	Vit B12 injections?	Y	N
Blood/Nutrient deficiencies?	Y	N	P		No. of pregnancies		No. of children			
Blood donor?	Y	N	P		Currently pregnant (females)?				Y	N
HOW MANY UNITS OF ALCOHOL DO YOU CONSUME ON AVERAGE PER WEEK? One unit of alcohol equals: 250 ml beer or lager, 1 glass (125 ml) of wine, 1 pub measure of spirits									
None	1 – 2 units				3 – 13 units		14 – 21 units		22+ units	
Do you smoke?	Y	N	P		Tobacco/Other		Brand and frequency			
Prolonged exposure to environmental toxins (e.g. agricultural pesticides, occupational solvents)									Y	N
Weight	kg	Height	cm		Waist	cm	Hips	cm		
IN THE PAST 3 MONTHS, HOW MANY TIMES A WEEK HAVE YOU CONSUMED THE FOLLOWING FOODS (please underline foods taken or exclude those not relevant)									
[0] Less than once per week	**[1] Once per week**				**[2] Twice per week**		**[3] Three times per week**			
[4] Four times per week	**[5] Five times per week**				**[6] Six times per week**		**[7] Every day**			
Hamburgers, Pizza					All legumes (beans, peas, lentils)					
Red meat (e.g. beef, lamb, mutton)					Potatoes with skin					
Fried chicken / cooked chicken with skin					At least 5 portions fruits and vegetables (per day)					
Hot dogs / Sausages					Whole grain breads. cereals (low GI wheat, oats)					
Salad dressings (excludes 'Lite' versions)					Broccoli, cauliflower, mushrooms					
Butter and margarine (excluding pro-active versions)					Turnips, artichokes, asparagus					
Fried eggs (excludes cooking, boiling and baking)					Avocado, spinach					
Full cream milk and dairy products					Oranges, grapefruits (pure fruit versions)					
Fried hot potato chips, crisps, corn chips,popcorn					Organ meats (e.g. liver, kidney, giblets)					
Biscuits, cake, cookies, pastries					Fizzy drinks, tea/coffee WITH SUGAR					
Supplements taken	Daily:				Occasionally:					
Food allergy / intolerance:										
Are you following a specific style of eating? (e.g. Vegetarian, Banting)					Y	N	My preference			
WHICH BEST DESCRIBES YOUR PHYSICAL ACTIVITY STATUS? (lasting more than 30 minutes)										
Complete lack of exercise	Exercise once a week				Exercise 2 – 3 times/week		Exercise 4+ times/week			
WHICH BEST DESCRIBES YOUR OCCUPATIONAL ACTIVITY?										
Sedentary (e.g. desk work, driving)					Moderate (e.g. housework)				Intense (e.g. gardener)	